

NEW HAMPSHIRE HOSPITAL

Attn: Health Information Department
36 Clinton St. Concord, NH 03301
Telephone 603-271-5300
Fax 603-271-5784

Patient's Name _____

Date of Birth _____

I (Print Name of Patient or Legal Representative) _____

authorize NH Hospital to disclose my protected health information as described below for the purposes of:

☐ Continuing Care ☐ Other _____**For Dates of Care From:** _____ **to:** _____ **OR** ☐ **Most Recent Admission/Discharge****Disclose To:** Name _____

Street _____

City/State _____

Phone Number: _____ Fax Number _____

Information To Disclose to the Above Person or Organization:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Record Abstract (Discharge Summary, Discharge Medication List, History/Physical, Admitting Psychiatric Evaluation) | | | |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Physical Exam | <input type="checkbox"/> Admission Psych Assessment | <input type="checkbox"/> Social Service Assessment |
| <input type="checkbox"/> Psychological/Neurological Testing | <input type="checkbox"/> Lab or Radiology | <input type="checkbox"/> EKG/EEG | <input type="checkbox"/> Immunization Status |
| <input type="checkbox"/> Other (list): _____ | | | |

By signing this Authorization for Disclosure of Protected Health Information, I understand that:

1. A Photocopy or fax of this authorization shall be as valid as the original.
2. This Authorization for Disclosure of Protected Health Information is not a required condition for treatment.
3. If the person(s) or organizations(s) authorized to receive the information is not a health plan or health care provider, the disclosed information may be re-disclosed and would no longer be protected by federal privacy regulations.
4. Under the NH Division of Behavioral Health regulation, He-M 311, (after May 1982): NH Hospital is obliged to disclose any information in its possession with a properly executed authorization.
5. The Authorization to Disclose Protected Health Information shall be effective for a period of one year. EXCEPTION: Disclosure of information to/from Community Mental Health Centers shall be a length of time to correspond with the term of any probate commitment (Conditional Discharge) to facilitate continued communication.
6. Information disclosed may include psychiatric, substance abuse, HIV infection, AIDS, or tests for HIV
7. Medical information may be disclosed via fax machine unless otherwise specified
8. I authorize disclosure of medical records identified as protected health information relating to a finding of No Probable Cause in accordance with NH RSA 135-C. Any court documents ordering me to be confined at NHH must be obtained from the issuing court, as the Hospital is not authorized to disclose those legal portions of the medical record
9. This authorization may be revoked at any time. The request to revoke this authorization must be in writing and delivered to the Health Information Department of NH Hospital. Upon receipt of written revocation, NH Hospital must immediately cease disclosure of medical information, except to the extent information has been disclosed prior to the date of revocation
10. I am entitled to a copy of this authorization after I sign it.

Complete this section ONLY if a minor has been treated for a sexually transmitted disease pursuant to RSA 141-C: 18, II
A competent minor aged 14 or older may consent to treatment for a sexually transmitted disease. Therefore, specific authorization of the minor is required for the disclosure of that information. If the parent/guardian authorized the treatment they would also authorize the disclosure of information.

____ Patient Initials ☐ Yes or ☐ No **OR** ____ Parent/Guardian Initials ☐ Yes or ☐ No

Signature of Patient/Legally Authorized Representative_____
Relationship if not signed by the patient_____
Date**Please include a phone number where we may reach you if we have questions about your request.****Telephone** _____

NEW HAMPSHIRE HOSPITAL
Authorization for Disclosure of
Protected Health Information

PATIENT IDENTIFICATION